FOR CAMP ONLY. CAN NOT BE USED FOR OUR SCHOOL PROGRAM.

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

A. TO BE COMPLETED BY PARENT OR GUARDIAN:

I REQUEST THAT MY CHILD ______________________________________, GROUP ____________, RECEIVE THE MEDICATION PRESCRIBED BELOW BY OUR LICENSED HEALTH CARE PROVIDER. THE MEDICATION IS TO BE FURNISHED BY ME IN THE PROPERLY LABELED ORIGINAL CONTAINER FROM THE PHARMACY. I UNDERSTAND THAT THE CAMP NURSE OR OTHER ASSIGNED PERSON WILL ADMINISTER THE MEDICATION.

SIGNATURE (PARENT / GUARDIAN) ____

ADDRESS: ____

TELEPHONE: HOME _____________________________ WORK: ____

CELL: ____ DATE:____

B. TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER:

I REQUEST THAT MY PATIENT, AS LISTED BELOW, RECEIVE THE FOLLOWING MEDICATION:

NAME OF CAMPER: __________________________________ DATE OF BIRTH: _________________________

DIAGNOSIS: ____

NAME OF MEDICATION : ____

PRESCRIBED DOSAGE, FREQUENCY AND ROUTE OF ADMINISTRATION: ____________________________

____

TIME TO BE TAKEN DURING CAMP HOURS: ____

DURATION OF TREATMENT: ____

POSSIBLE SIDE EFFECTS AND ADVERSE REACTIONS (IF ANY): _____________________________________

____

OTHER RECOMMENDATIONS: ____

NAME OF LICENSED PRESCRIBER & TITLE: ____
(PLEASE PRINT)

PRESCRIBER'S SIGNATURE: ____ DATE: ____________________

ADDRESS: ____ PHONE: ____________________________

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